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Medicare Choices

A beneficiary's guide to options under Medicare

This list is designed to help you assess available options. It does not imply endorsement of any option by the Statewide Health Insurance Benefits Advisors (SHIBA) HelpLine or the Office of the Insurance Commissioner.

Medicare does not pay 100 percent of all medical bills. It is intended to increase access to health care and reduce its financial burden on older, retired or disabled Americans.

Medicare offsets medical expenses by providing a basic foundation of benefits. Individuals are still responsible for some costs out of pocket. There are deductibles, co-payments, and—in some cases—charges over and above what Medicare considers reasonable and necessary, which Medicare won't pay.

All of these expenses have been considered Medicare's "gaps," and most Medicare beneficiaries find they need a plan, policy or program to fill them.

The passage of the Balanced Budget Act of 1997 made possible multiple options for filling gaps in Medicare coverage. This legislation introduced the concept of **"Medicare+Choice"**–an "umbrella" under which many Medicare-enhancing options are grouped.

Not all options allowed for in the new legislation have materialized in the marketplace. This fact sheet provides basic information and some of the pros and cons of each option.

Any method of supplementing Medicare has advantages and limitations. No option will be right for everyone.

Medicare+Choice options may change in the future. More detailed information can be obtained by consulting a **SHIBA (Statewide Health Insurance Benefits Advisors) HelpLine** volunteer. These advisors are trained by expert staff of the Insurance Commissioner's Office.

Call **1-800-397-4422** for a referral to the counselor nearest you. For more information about SHIBA HelpLine and the Insurance Commissioner's Office, see the last page of this guide. ■

Original Medicare (Fee-for-Service):

The Original Medicare plan (sometimes called fee-for-service or "traditional Medicare") lets beneficiaries obtain care for Medicare-approved, medically necessary services from any Medicare-contracting provider. Patients pay their share of expenses out of pocket.

Help with some of those out-of-pocket expenses can come from Medigap policies—the standardized A through J plans. An employer's retiree plan may also help fill Medicare's gaps and pay of out-of-pocket costs.

Medigap policies are offered by insurance companies. Each plan covers a different set of "gaps." ➡

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Availability

Original medicare (fee-for-service, or "traditional Medicare," or "standard Medicare") is the default option for all enrolled beneficiaries. It is how the basic Medicare program works.

To fill the "gaps," Medigap policies are available from a wide variety of insurance companies. Learn about what the standardized plans cover, and choose which one best addresses the gaps you need to fill. SHIBA HelpLine publishes a convenient chart comparing the 10 standardized plans (find it on the SHIBA HelpLine website; see last page of this handout).

Then, when shopping for a policy, see the chart *Approved Medigap (Medicare Supplement) Plans* for a comparison of actual policies sold in Washington state.

Those with insurance through a current or former employer may find that the employer's plan fills Medicare's "gaps" adequately. Employer plans can sometimes be Medigap-*like* policies, but they are not standardized.

EMPLOYER PLANS

Retirees with employment-related benefits should be cautious about leaving the plan to try a standard Medigap policy (or any Medicare+Choice option). It's likely that you *won't* be able to get back into the employer's plan. Always check with your employer first.

Some of the most common employer plans are Public Employees Benefits Board (PEBB), TriCare for Life, and Federal Employees Health Benefits (FEHB).

Advantages

Traditional Medicare plus a Medigap and/or employer plan offers freedom—to choose doctors and hospitals, switch providers, and see specialists without referral.

- Medicare-approved care is covered anywhere in the U.S.; some limited emergency care is covered in Canada and Mexico and, with some Medigaps, in foreign countries.
- Medigap policies are guaranteed renewable (cannot be cancelled unless you don't pay premium).
- During specific enrollment periods, Medigap policies are guaranteed issue. This means you cannot be turned down for a policy due to your health status. (Outside of these enrollment periods, you may be denied coverage.*)

Limitations

- Routine, preventive, wellness, and alternative care not covered by Medicare also *may* not be covered by the supplemental coverage.
- Some Medigap plans may have up to a 90-day waiting period for pre-existing conditions.
- Under this system, all billings and claims paperwork is your responsibility (unless your supplemental plan has automatic/electronic claims processing). ■

*IF YOU ARE DENIED MEDIGAP COVERAGE

If you are denied coverage with a Medigap plan, you will be eligible for the Washington State Health Insurance Pool (WSHIP), Plan 2. For more information on WSHIP, visit their web site at: http://www.onlinehealthplan.com/oasys/wship or consult a SHIBA HelpLine volunteer about the pros and cons of WSHIP.

Medicare Savings Programs

If you are a Medicare beneficiary, you may be eligible for one of several Medicare Savings Programs. These government programs help pay some Medicare costs for people with limited income and resources. They include Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB) and Qualifying Individual (QI-1).

These programs help eligible people by paying Medicare premiums, deductibles and other Medicare-related costs, saving some beneficiaries up to $704.40 a year. They work with either standard Medicare fee for service or Medicare managed care plans.

There are income guidelines, which change every year. In 2003, income limits to qualify are:

QMB	$749 individual	$1010 family
SLMB	$898 individual	$1212 family
QI-1	$1011 individual	$1364 family

Assets limits are $4,000 single, $6,000 couple.

If you qualify for QMB, its coverage is similar to a Medigap plan and you may not need to purchase one.

The SLMB and QI-1 programs will pay your Medicare Part B premium.

If you qualify (based on your income and assets), you may also be eligible for Medicaid assistance, which will cover prescriptions in addition to QMB benefits.

For the most current qualifying limits, see the Department of Social and Health Services (DSHS) brochure *Saving Money on Medicare.* Or you can call 1-800-562-3022, or go to your local Community Services Office (CSO), which is listed in the blue "Government" pages of your local phone book.

Private Fee-for-Service

In the "traditional" Medicare system, beneficiaries and Medicare share costs on a per-service basis for Medicare-approved, medically necessary services. They can get these services from any provider who accepts Medicare.

An additional fee-for service system under Medicare+Choice, called **Private Fee-For-Service (PFFS)**, allows Medicare beneficiaries to buy plans from private insurance companies that cover both Medicare-covered services *and* supplemental coverage.

The company you choose is paid by Medicare to provide coverage for your Medicare benefits. You'll continue to pay Part B premiums to Medicare, and probably also a premium directly to the insurance company for the plan's supplemental coverage.

In order to compete, companies *might* enhance the basic Medicare package with various additional benefits. This means the plan *may* cover some Medicare gaps, prescriptions, preventive and routine services, and/or alternative therapies.

Availability

There is currently only one PFFS plan offered in Washington. It is *not* an option for people with End-Stage Renal Disease (ESRD).

For more information, see the SHIBA HelpLine chart "Medicare + Choice Plans 2003"

Advantages and Limitations

A PFFS plan covers all Medicare-covered care from any provider accepting Medicare. It offers the freedom to choose doctors and hospitals, switch providers at your discretion, see specialists without referral, and move or travel without losing coverage or paying extra.

- Be aware that a provider can choose to accept or reject participation with this plan, so check with your health care provider(s) before signing up.
- Plans must renew their contracts with Medicare on an annual basis, thus leaving the possibility of termination.
- PFFS is guaranteed issue.
- PFFS plans may be less expensive premium-wise (although there are no ceilings on premiums), but may have higher out-of-pocket costs such as co-pays for hospital, doctor visits, home health care and durable medical equipment.
- There is no limiting charge. (A limiting charge is the 115% maximum a physician who does not accept assignment may legally charge for a Medicare-covered service. Health care providers who "accept assignment" agree to bill no more than Medicare will approve, but those who don't accept assignment can charge any amount if there is no limiting charge.)

Check the plan's out-of-pocket expenses closely before making your decision.

Managed Care/HMOs

Under Medicare+Choice, health maintenance organizations (HMOs) are in a category of options commonly called **managed care.** Any Medicare beneficiary can obtain health care through a *Medicare-contracting* HMO, *if* one is available and serving your area.

HMOs are sometimes thought to represent all managed care, but the HMO is actually only one type of managed care organization (MCO). An MCO provides pre-paid medical and preventive care to enrolled members through a network of doctors, facilities and other health care providers.

An HMO may maintain its own health center and staff, or it may contract with a group of physicians who treat plan members as well as private patients. In some cases, physicians may belong to more than one managed care organization.

The plan *may* also cover a variety of "extras"—such as preventive or routine care—that would not ordinarily be covered by Medicare.

HOW IT WORKS

- Medicare prepays a monthly amount to the plan on your behalf.
- The HMO in turn must deliver all *medically necessary* Medicare-covered treatment.
- Depending on the plan, you may pay the plan a fixed monthly premium.
- You continue to pay your Part B premium directly to Medicare.
- Co-payments may be required for some services.
- You don't pay Medicare deductibles/coinsurance.

Availability

In the past few years, tens of thousands of Medicare beneficiaries in Washington state (and hundreds of thousands nationwide) lost their Medicare managed care plans when many plans terminated their contracts with Medicare.

This is also called "nonrenewal" and is a risk of Medicare managed care. Medicare can decide not to renew its contract with a plan, or vice versa (some plans terminated their contracts with Medicare because Medicare's payment to them reportedly didn't cover the cost of care they provided to beneficiaries).

Terminated beneficiaries still have Medicare coverage, but are forced to find a replacement method for supplementing Medicare to fill the gaps–whether through another managed care plan, or a different approach such as Medigap or employer coverage.

After several consecutive years of Medicare managed care terminations, there are fewer managed care options for beneficiaries than ever. In addition, some insurers have been given permission by the federal government to limit enrollment in their plans.

However, some plans that accept Medicare enrollees do still exist, mostly in Western Washington. See the SHIBA HelpLine chart *Medicare+Choice Plans 2003* for more information.

Advantages

- Wellness programs, preventive services and routine care are often covered by managed care plans.
- Often there is little paperwork involved—no bills or claim forms.
- Premiums and co-payments are usually modest.
- During open enrollment periods, enrollment cannot be refused based on health or pre-existing conditions (except for End-Stage Renal Disease).
- There are no waiting periods for pre-existing conditions.
- Physicians and facilities are subject to federal quality assurance requirements.

Limitations

- Except for emergency or urgently-needed care, choice of physicians is limited to the plan's staff or network. You assign or "lock in" your Medicare benefits to the plan; if you want to get Medicare-covered care outside the network, you'll have to pay for it yourself.
- Specialists may not be covered without referral from your primary care physician (PCP).

• You must live in a plan's service area to join (except in special cases involving HMO-model employer plans). All services must be obtained within the plan's service area. And if you travel extensively outside the county you live in, you'll want to look closely at the plan's rules for services out-of-area.

(NOTE: Some HMOs may offer a *Point of Service* option, which allows you to go outside the plan's network for some services. In most cases, you'll pay more when you use this option—a premium, higher co-payment, deductible, or coinsurance.)

• If you move out of the plan's service area for over one year, membership is automatically cancelled.

• Plans, their Medicare contracts, or network providers can be cancelled.

• Plans may also close enrollment periodically to maintain patient/provider ratios (if they reach maximum capacity). ■

Preferred Provider Organizations (PPOs):

Like HMOs, PPOs are a **coordinated care** option. PPOs and HMOs differ from each other in two key ways: who administers them, and to what degree a member is required to receive care from plan staff or affiliated providers.

The PPO model is administered by an insurance company, and it allows more freedom than an HMO to seek care outside the network—but at a cost.

A PPO uses a network of providers who contract to provide services at pre-negotiated rates. Enrollees may go outside the network for services—if they're willing to pay more. The plan pays a higher percentage of costs when you use "preferred providers," less if you go to a non-preferred provider.

Under Medicare+Choice, PPOs work with Medicare in way that is similar to managed care: Medicare prepays a monthly amount to the plan on your behalf; you may pay a fixed monthly premium; you'll continue to pay your Part B premium directly to Medicare. The PPO is required to deliver all *medically necessary* Medicare-covered care.

You won't pay Medicare deductibles or coinsurance, but the plan may have its own deductibles, co-payments, or coinsurance. These are greater for out-of-network services (for example, you may pay 10% of the approved amount for a preferred provider's service, but 40% for that of a non-preferred provider).

Advantages

• You can use your Medicare benefits outside the plan (have Medicare and the plan pay a share of Medicare-covered care even if you go outside the affiliated provider network).

• You may be able to self-refer to specialists or other providers without a primary care physician referral.

• You can reduce out-of-pocket expenses within the plan by seeing preferred providers.

• There are no waiting periods and the plans are guaranteed issue except for End-Stage Renal Disease patients.

• There may be some additional (not covered by Medicare) benefits (e.g., dental care, hearing and vision services, routine physical exam, acupuncture). These would have a co-payment and limited benefits.

Limitations

• A PPO, its Medicare contract, or provider contracts may be cancelled. If your physician and the plan decide not to continue working together, you may have to change plans or doctors.

• There may be no benefit for out-of-network care (you would pay 100%).

Availability:

The Balanced Budget Act of 1997 provided for Medicare, to contract directly with PPOs. Currently, a Medicare PPO plan is offered in Washington only to Clark County residents. ■

Medical Savings Accounts

MSAs are tax-free bank accounts which hold money earmarked for health care. Under Medicare+Choice, the government created *Medicare* Medical Savings Accounts (there are also non-Medicare MSAs) on a demonstration basis. Enrollment was limited to 390,000 Medicare beneficiaries nationwide.

None are currently available in Washington, but you might be eligible for one through a national association.

A Medicare MSA combines two sources of coverage for health care expenses: the account itself, and a high-deductible (maximum $6,000) insurance policy that backs it. Account funds are available for any medical expense until the deductible is met; after that, the policy would cover 100 percent *of allowed charges for Medicare-approved care* (plus Medicare deductibles and coinsurance). Additional coverage or restrictions may vary from plan to plan.

The account itself is funded by Medicare's annual contribution, determined by your area's "capitation"* **less** the amount Medicare will pay monthly for your MSA's insurance premiums. (Premiums will vary by plan.)

You pay your Part B premium directly to Medicare. If medical expenses exceed your MSA funds for that year, you must pay those expenses until the insurance deductible is met.

*HOW MEDICARE PRE-PAYS PLANS

Medicare prepays health plans a specific amount on your behalf (sometimes called "capitation"). It varies from region to region based on the average monthly cost for a person in a given age group and geographic area (Average Annual Per Capita Cost or AAPC). Every Medicare + Choice option would receive the same amount on your behalf. What differs from plan to plan is who gets paid and when. See other pages of this guide for more on how Medicare pre-pays specific plans.)

Unspent funds amass in the account and are carried to the next year. Upon the beneficiary's death, remaining funds become the property of estate.

Advantages:

- MSAs offer the opportunity to partly self-insure, yet have the safety net of insurance underneath.
- If medical expenses are low, you can keep and save unspent portions of Medicare's capitation* (instead of having that money paid to, controlled by, and kept by a plan whether or not you incur expenses).
- Account funds are not taxable as long as they're withdrawn only for qualified medical expenses.
- *If* the MSA's insurance policy is a fee-for-service/indemnity-type plan, you can freely choose or switch doctors and hospitals, specialists, health services, and types of care. (Be aware that the backup insurance varies by plan; if it's a coordinated care-type plan, there may be managed care-type restrictions.)
- MSA funds can be used for medical expenses not covered by Medicare (e.g. prescriptions, long-term care).

Limitations:

- You can only disenroll once a year.
- If expenses exceed Medicare's contribution to your MSA, you pay out of pocket till deductible is met.
- While *account* funds can be used for any qualified medical expense, the backup insurance covers only *allowed charges for Medicare-approved care* (plus Medicare deductibles and coinsurance).
- Funds withdrawn for anything but qualified medical expenses are subject to taxation and other penalties.
- Some beneficiaries—such as hospice patients, Medicaid recipients, and federal retirees—are not eligible for MSAs.

Availability:

This was a pilot project starting in 1999, with limited enrollment to about one percent of Medicare beneficiaries. None are currently available in Washington state.

Religious and Fraternal Organization Plans

Under Medicare+Choice, organizations with members—such as churches or associations—may contract with providers for health care services in a coordinated care setting. Enrollment will be open only to members of the group that sponsors the plan. These plans will be known as Religious Fraternal Organizations (RFOs).

Advantages:

- You may be able to get your managed care from an organization you care about, to which you want to contribute, and which reflects your values or beliefs.
- Managed care may involve less paperwork than fee-for-service (virtually no bills and claims forms).
- Premiums and co-payments may be modest compared to fee-for-service systems.
- Enrollment cannot be refused based on health or pre-existing conditions during specified enrollment period (except for End-Stage Renal Disease).
- There may not be waiting periods for pre-existing conditions.

Limitations:

- You must be a member of the group to join the plan.
- Plan stability could be a concern unless the organization is experienced in administering a health care plan.
- As with other managed care, your choice of physicians will be limited to the plan's provider network. You will lock your Medicare benefits into the plan, and if you get Medicare-covered care from a non-affiliated provider, you'll have to pay for it yourself.
- It is anticipated that, as with other managed care, specialists will only be covered with referral from a primary care physician (PCP).
- As with other managed care, there may be a plan service area in which you must live to join, and in which all covered care must be received. If you move out of the plan's service area for one year or more, your membership is automatically cancelled.
- The plan or its Medicare contract may be cancelled—it won't be "guaranteed renewable."
- If your physician and the plan decide not to continue working with each other, you may have to change plans—or doctors.

Availability:

RFOs are provided for by the Balanced Budget Act of 1997. Groups in Washington may or may not form RFOs. **To date, none exist in Washington state,** but you might be eligible for one through a national association.

Other resources

Other valuable resources for understanding and evaluating your options include these SHIBA HelpLine/Office of the Insurance Commissioner publications:

- *Medicare, Medigap & You*
- *Retirement & Your Health Insurance*
- *Health Insurance Options for People with Disabilities*
- *Health Insurance Options in the Individual Market*
- *Consumer's Guide to Financing Long-Term Care*
- *Paying for Prescription Drugs*

These charts offer specific plan information:

- *Approved Medigap (Medicare Supplement) Plans*
- *Medicare+Choice Plans 2003*

Order these and other publications online or by phone *(see contact information below and at right).*

Publications in Spanish and Chinese are also available from SHIBA HelpLine and Centers for Medicare and Medicaid Services (CMS).

Office of the Insurance Commissioner
www.insurance.wa.gov

SHIBA HelpLine
www.insurance.wa.gov/consumers/shiba/default.asp

Centers for Medicare and Medicaid Services (CMS)
Consumer Services (206) 615-2354
Medicare Hotline (800) 633-4227
Medicare Managed Care (206) 615-2351
www.medicare.gov

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SHIBA HelpLine

Get trained assistance when making health insurance choices. For more information about these and other health insurance and access questions, call **Statewide Health Insurance Benefits Advisors (SHIBA) HelpLine.**

SHIBA is a **free**, confidential, impartial counseling resource sponsored by the Office of the Insurance Commissioner to help you evaluate, choose and use your health insurance.

Volunteer advisors, extensively trained by Insurance Commissioner Mike Kreidler's staff, have up-to-date information on all health insurance concerns.

Your local SHIBA HelpLine volunteer can help you get more information on companies, evaluate a policy or do side-by-side policy comparisons, answer questions, and educate you on a wide range of health insurance and access issues.

To be referred locally call:

1-800-397-4422

TDD: 1-360-664-3154

www.insurance.wa.gov

If you have insurance questions or concerns, the Insurance Commissioner's Consumer Advocacy staff includes experts in all lines of insurance (auto, homeowner, life, disability and health) and offers free assistance to consumers. Consumer Advocacy also has the authority to investigate formal complaints and to enforce insurance law on behalf of consumers.

INSURANCE COMMISSIONER'S TOLL-FREE CONSUMER HOT LINE
1 (800) 562-6900